Nursing Commission
PO Box 47864
Olympia, WA 98504-7864
360.236.4700

Registered Nurse Trained Outside the US Application Packet

Contents:

Important Social Security Number Information:

Social Security Number: You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with Initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Nursing Commission
PO Box 47864
Olympia, WA 98504-7864

Contact us:

360.236.4700

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Washington State Department of Health
Nursing Commission
PO Box 47864
Olympia, WA 98504-7864
360.236.4700

Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly. It is your responsibility to submit the required forms required.

☐ **Application Fee**. This fee is non-refundable. You can check the **fee page** for current fees.

☐ **#1: Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the city, state and country where you were born.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change.
See **WAC 246-12-310**.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **#2: Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **#3: Professional Education:**
Check next to high school diploma or GED. List in chronological order your educational preparation and post-graduate training. You must include the school you are currently attending if applicable. If you need more space, attach a piece of paper.

☐ **#4:License in Other State(s) or Country(ies)**
List all states/countries where you have held an RN or an LPN license. List these licenses in the order they were issued.

☐ **#5: Other License:**
List all states where any health care licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

☐ **#6: AIDS Education and Training Attestation:**
AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training. This is required by **WAC 246-12-260** course content can be found in **WAC 246-12-270**.

☐ **#7: Applicant's Attestation:**
You must sign and date this for us to process the application. Read very carefully.

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License Requirements

Please Read: **Licensing examination: WAC 246-840-050.**
Licensing of graduates of foreign schools of nursing: WAC 246-840-045.

Applicants Trained Outside The U.S. For NCLEX-RN Exam

All applicants who graduated from nursing schools outside the United States, that have not been licensed in another state or jurisdiction, must have their transcripts evaluated in a course by course evaluation by Graduates of Foreign Trained Nursing Schools (CGFNS). Please visit their Web site for instructions: **www.cgfns.org**.

All applicants who graduated from nursing schools outside the United States, and English is not the primary language, must also complete and pass the Test of English as a Foreign Language (TOEFL exam). You can view their Web site at: **www.toefl.com**.

You will not be eligible for the NCLEX until you have completed the CGFNS transcript evaluation service and passed the TOEFL exam. We will get your CGFNS evaluation directly from CGFNS. You must have your TOEFL scores sent directly to us.

When you successfully complete the CGFNS evaluation and TOEFL exam register with Pearsonvue to take the NCLEX-RN exam. You can register at: **www.pearsonvue.com**. This Web site has an NCLEX-RN candidate bulletin to answer testing questions. If you pass the exam, and meet all other licensing requirements, your license will be issued within a week after the exam. If you fail the exam, the candidate bulletin will guide you on how and when you can retest. There is a 45 day waiting period between examinations.

Applicants Trained Outside The U.S. For Endorsement

If you were licensed in a state or U.S. jurisdiction and you completed a foreign nursing program after 12-31-71, you must have taken and passed the NCLEX-RN to be licensed. The following information is needed to proceed to license in Washington State by endorsement.

Verification of RN license from your original state of license:

Visit **www.nursys.com** to find out if your original state of license is a participating state with the national license verification database. If it participates with NURSYS, follow the directions to register. We can use the site to verify your license.

If your original state of license does not participate with NURSYS, send the verification form in this application packet to your original state of license. They must complete it and send it back to us. You should check with that state to find out if a processing fee is charged. You can find contact information on the NURSYS website **https://www.ncsbn.org/515.htm**. A verification is valid for six months from the date processed.

Proof of a current/active RN license:

If your license at your original state of licensure is not current or active we will need proof of a current or active license. If you have an active license from a state that participates with NURSYS, we can obtain license information. If you do not have a current or active license with a NURSYS participating state, visit the state Web site where your license is active. Print the page showing a current or active license and send it with your application. Do not send a copy of your license.

Attention: All Applicants Trained Outside the U.S.

The state of Washington requires that your transcripts with degree listed must be translated into English and come directly from the school, another state board, or CGFNS.

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Background Check Stamp Here

Date Stamp Here

Revenue 0258010000

Registered Nurse Trained Outside the US License Application

You must check the box next to Examination or Endorsement:

☐ Examination ☐ Endorsement

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)

___ ___

☐ Male
☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth

City | State | Country

Address

City | State | Zip | County

Country

Phone ( ) | Fax ( ) | Cell ( )

Email address

Mailing address (if different from above)

City | State | Zip | County

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

For Office Use Only

☐ AIDS ☐ COC ☐ Verif (Foreign) ☐ Scripts ☐ CGFNS ☐ TOEFL
☐ Active License ☐ Other ☐ PDQ
☐ NCLEX Registration # _____

License Date _____ License # _____ Validation #_____
Graduation Date _____ School Code _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ..... ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ..... ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ..... ☐ ☐
   b. Diverted controlled substances or legend drugs? ..... ☐ ☐
   c. Violated any drug law? ..... ☐ ☐
   d. Prescribed controlled substances for yourself? ..... ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? . ..... ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ..... ☐ ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ..... ☐ ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ..... ☐ ☐

3. Professional Education

High school graduate? ☐ Yes ☐ No

If no, GED? ☐ Yes ☐ No

Institute		Name/Location	Start Date	End Date	Diploma/Degree Granted
College	University				

4. License(s) in Other State(s) or Country(ies)

List all states/countries where you have held a registered nurse license. List these licenses in the order they were issued.

Check One		State/Country	Current Expiration Date
As RN	As LPN		

State or **country** in which originally licensed by examination. _____

Year license first issued _____ as an ☐ RN ☐ LPN

Have you taken the State Board Test Pool Examination (SBTPE) or NCLEX in the United States? ☐ Yes ☐ No

If yes, state _____ as an ☐ RN ☐ LPN

Have you ever applied for license in Washington prior to this application? ☐ Yes ☐ No

If yes, under the name of _____ as an ☐ RN ☐ LPN Approximate date _____

5. Other License(s)

List all health care licenses held and in what state. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

State	Profession	License Type	License		Method of License
			Year issued	Number	

6. AIDS Education and Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of the state
(Print applicant name clearly)
of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
City/State

By: _____
Original Signature of Applicant

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Education Certification

Applicant: Complete this section and mail to the school of nursing from which you graduated.

Present Name Last _____ First _____ Middle _____ Maiden _____

I graduated on _____ from the school of nursing under the name of
mm/dd/yyyy

Date of Birth _____ Social Security Number _____
mm/dd/yyyy Required for license

I hereby request this certification be completed, a transcript included and mailed to:
Department of Health, Washington Nursing Commission, PO Box 47864,Olympia, WA 98504-7864.

Signature of Applicant _____

Address _____

_____

Applicant, please do not write below this line

To be completed by the chief administrative officer of the school of nursing from which the above named applicant graduated. Please return this form directly to the Washington Nursing Commission.

Recorded Name of Graduate _____

Name of School of Nursing _____

Location _____

School Approved By _____

Date Student Entered _____ Date Course Completed _____

Length of Course _____ Diploma/Degree Received _____
mm/yyyy mm/yyyy

Please attach an official **transcript** (record of all subjects taken, including hours of class and weeks of clinical experience) for this applicant. This document must carry the school seal or stamp and signature of the chief administrative officer.

School Seal

Chief Administrative Officer Signature _____

Title _____

Date _____

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License Verification

Applicant: Complete this section and mail to the Government agency where original license was granted.

Present Name Last _____ First _____ Middle _____ Maiden _____

I hereby request the verification form below be completed and mailed to:
Department of Health, Washington State Board of Nursing, PO Box 47864, Olympia, WA 98504-7864 U.S.A.

I was registered by your bureau under the name _____

and certificate number _____ Dated _____

Signature of applicant _____

Address _____

_____

Applicant: please do not write below this line

To be completed by the nurse license authority in country where applicant was originally licensed. Please return this form directly to the Washington State Board of Nursing.

License Certification

This is to certify _____ after passing a governmental

examination was granted a certificate of license as _____

according to the laws of the country of _____ on _____

The certification was number _____
Country dd/mm/yyyy

The license is currently in good standing: ☐ Yes ☐ No

If other basis for license (than governmental examination) please explain on the reverse side.

The school of nursing from which the applicant graduated was approved by this government at the time of graduation: ☐ Yes ☐ No

Name of licensing/registration agency _____

(Affix official seal here)

Signature _____

Title _____

Date _____

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License Verification

Please complete the top portion of this form and forward to your **original** state of license.
(Please contact your original state of license for fee charged and processing time.)

Check One Box: ☐ **Registered Nurse** ☐ **Licensed Practical Nurse**

Name Last	First	Middle Initial
Social Security Number (If you do not have a social security number, see instructions.) — —		Previous Last Names Used
Address		
City	State / Zip	County
Name as it appears on original license	Original State of License	Current State of License

I hereby authorize the release of my license data to the Washington State Nursing Commission.

Signature _____ Date _____

This portion to be completed by original state of license and mailed to: Washington State Nursing Commission, P.O. Box 47864, Olympia, Washington 98504-7864.

This is to certify _____ was issued license number _____

on _____ to practice ☐ registered nursing ☐ licensed practical nursing (vocational nursing).

Licensed by: ☐ Exam ☐ Endorsement ☐ Other (specify)

Current License Status: ☐ Active ☐ Inactive ☐ Lapsed

Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)? ☐ Yes ☐ No (if yes, attach explanation)

Disciplinary action pending? ☐ Yes ☐ No (if yes, attach explanation)

Nursing Education Program Completed:

Location (City & State):

Type of Nursing Program: ☐ Diploma ☐ BSN ☐ ADN ☐ LPN ☐ Other (specify)

Date of Completion

Examination Scores: State Board Test Pool Exam

	Score	Series
Medical	_____	_____
Psychiatric	_____	_____
Obstetric	_____	_____
Surgical	_____	_____
Nursing of Child	_____	_____
LPN/VN	_____	_____

NCLEX:

RN _____ Series _____

LPN _____ Series _____

NCLEX CAT:

RN _____ Date _____

LPN _____ Date _____

Signature _____ State _____ Date _____

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Health Professions Reference Numbers and Links

RCW/WAC Links

Uniform Disciplinary Act..... UDA RCW 18.130

Administrative Procedure Act ..... APA RCW 34.05

Administrative procedures and requirements..... WAC 246-12

RCW Registered Nursing ..... RCW 18.79

WAC Registered Nursing ..... WAC 246-840

On-Line

AIDS Training ..... Reference Page

Nursing Quality Assurance Commission ..... Web Page